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IN THE UNITED STATES BANKRUPTCY COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

FRESNO DIVISION

In re Tulare Local Healthcare District, Debtor. Tax ID #: 94-6002897 Address: 869 N. Cherry Street Tulare, CA 93274	Case No. 17-13797 Chapter 9 DC No.: WJH-4 **EXHIBITS IN SUPPORT OF DEPARTMENT OF HEALTH CARE SERVICES' MOTION FOR LEAVE TO FILE AMENDED PROOF OF CLAIM 197** Date: May 27, 2020 Time: 9:30 a.m. Place: 2500 Tulare Street Fresno, CA 93721 Courtroom 13 Judge: The Honorable René Lastreto, II

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In support of its motion for leave to amend Proof of Claim 197, Creditor Department of Health Care Services (DHCS) proffers the following exhibits:

Exhibit A	Amended Proof of Claim 197
Exhibit A-1	Amended Declaration of Shiela Mendiola in Support of Amended POC 197
Exhibit A-1(a)	Spreadsheet of Interim Payments & Estimated Overpayments for 2002-2016

Dated: April 9, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
NIROMI W. PFEIFFER
Supervising Deputy Attorney General

/s/ Grant Lien

GRANT LIEN
Deputy Attorney General
Attorneys for Creditor
Department of Health Care Services (DHCS)

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EXHIBIT A

Amended Proof of Claim 197

Fill in this information to identify the case:

Debtor 1: Tulare Local Healthcare District
dba Tulare Regional Medical Center

Debtor 2 (Spouse, if filing):

United States Bankruptcy Court for the: Eastern District of California

Case number: 17-13797

Official Form 410

Proof of Claim AMENDED PROOF OF CLAIM 197

04/19

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Department of Health Care Services
   Name of the current creditor (the person or entity to be paid for this claim)
   Other names the creditor used with the debtor

2. **Has this claim been acquired from someone else?**
   ☑ No
   ☐ Yes. From whom?

3. **Where should notices and payments to the creditor be sent?**
   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

   Where should notices to the creditor be sent?
   Department of Health Care Services, MS 0010
   Name
   P.O. Box 997413
   Number Street
   Sacramento CA 95899
   City State ZIP Code
   Contact phone 916-345-8387
   Contact email Mark.McClenning@dhcs.ca.gov

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Contact phone
   Contact email

   Uniform claim identifier for electronic payments in chapter 13 (if you use one):

4. **Does this claim amend one already filed?**
   ☐ No
   ☑ Yes. Claim number on court claims registry (if known) 197 Filed on 04/06/2018 MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☑ No
   ☐ Yes. Who made the earlier filing?

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
   - ☐ No
   - ☑ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 2 8 9 7

7. **How much is the claim?** $ 5,520,423.33
   estimate from 2002-2016
   estimate for 2016-2017 not yet available

   Does this amount include interest or other charges?
   - ☑ No
   - ☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

   Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

   Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

   Limit disclosing information that is entitled to privacy, such as health care information.

   Overpayment of supplemental reimbursement under Medi-Cal

9. **Is all or part of the claim secured?**
   - ☑ No
   - ☐ Yes. The claim is secured by a lien on property.

   Nature of property:
   - ☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim.*
   - ☐ Motor vehicle
   - ☐ Other. Describe: _____

   Basis for perfection: _____

   Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

   Value of property: $_____

   Amount of the claim that is secured: $_____

   Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amounts should match the amount in line 7.)

   Amount necessary to cure any default as of the date of the petition: $_____

   Annual Interest Rate (when case was filed)_____%
   - ☐ Fixed
   - ☐ Variable

10. **Is this claim based on a lease?**
    - ☑ No
    - ☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**
    - ☐ No
    - ☑ Yes. Identify the property: Equitable recoupment from Medi-Cal payments.

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one.*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $3,025* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $13,650*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/22 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box.

☐ I am the creditor.
☑ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 04/09/2020
MM / DD / YYYY

Signature

Print the name of the person who is completing and signing this claim:

Name: Grant (First name) Middle name: Lien (Last name)

Title: Deputy Attorney General

Company: Office of the Attorney General
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 1300 I Street, Suite 125
Number Street

Sacramento (City) CA (State) 94244 (ZIP Code)

Contact phone: 916-210-7920 Email: Grant.Lien@doj.ca.gov

EXHIBIT A-1

Amended Declaration of Shiela Mendiola in Support of Amended Proof of Claim 197

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IN THE UNITED STATES BANKRUPTCY COURT

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FRESNO DIVISION

In re Tulare Local Healthcare District, Debtor, Tax ID #: 94-6002897 Address: 869 N. Cherry Street Tulare, CA 93274	Case No. 17-13797 Chapter 9 DC No.: WJH-4 **AMENDED DECLARATION OF SHIELA MENDIOLA IN SUPPORT OF AMENDED PROOF OF CLAIM 197**

I, Shiela Mendiola, declare as follow:

1. I have been employed by the Department of Health Care Services (DHCS) as the Section Chief of the Medi-Cal Supplemental Payment Section since January 2015. In that position, I oversee supplemental payment programs for the Safety Net Financing Division and am

a custodian of records for the Supplemental Reimbursement for Public Outpatient Hospital Services Program.

2. California Welfare and Institutions Code section 14105.96 provides supplemental reimbursements under California's Medi-Cal (Medicaid) program for an outpatient department of a general acute care hospital that is owned or operated by a city, county, city and county, the University of California, or health care district, which meets specified requirements and provides outpatient hospital services to Medi-Cal beneficiaries. Supplemental reimbursement under the Supplemental Reimbursement for Public Outpatient Hospital Services Program reimburses for hospital costs that are in excess of the payments the hospital receives for outpatient hospital services from any source of Medi-Cal reimbursement.

3. Interim payments are calculated using cost to charge ratios from cost reports, as well as Medi-Cal Fee-for-Service (FFS) charges and payments from provider submitted claims. Final reconciliations require cost to charge ratios to be reconciled to audited cost reports and Medi-Cal FFS charges, and payments reconciled to data from DHCS' internal Medicaid Management Information System (MMIS). California State Medicaid Plan, Attachment 4.19-B, pp. 47-48. During final reconciliations, adjustments are made for underpayments and overpayments.

4. When DHCS filed its original POC 197 on April 6, 2018, it could not include a specific amount for its claim because final reconciliations were still pending for Fiscal Year (FY) 2002-03 through the bankruptcy filing in September 2017.

5. Since April 6, 2018, DHCS has audited the cost reports for FY 2002-03 through FY 2015-16, using the methodology described in paragraph 3, and can now estimate the final reconciliation amount for that period to be an overpayment of $5,520,423.33. Attached as Exhibit 1(a) is an Excel Spreadsheet itemizing the interim payment and estimated overpayment for each fiscal year from 2002-2016 based on the methodology described in paragraph 3, and the total overpayment for that time period of $5,520,423.33. However, audited cost reports for FY 2016-17 are not yet available, so FY 2016-17 final reconciliation amounts still cannot be estimated.

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I declare under the laws of perjury of the State of California that the statements in this declaration are true and correct.

Executed in Sacramento, California on April 9, 2020.

Shiela Mendiola

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EXHIBIT A-1(a)

Interim Payments & Estimated Overpayments for 2002-2016 in Support of Amended Proof of Claim 197

AB 915 Public Hospital Outpatient Services Supplemental Reimbursement Program

Final Reconciliation Estimated Overpayments, as of February 12, 2020, for Tulare Healthcare District

Tulare participated in AB 915 FYs 2002-03 through FY 2016-17.

Final reconciliation process is still pending and has not been finalized. Amounts below are estimates subject to change.

	Interim Payments	Final Reconciliation - Estimated Overpayment
FY 2002-03	$ 432,176.53	$ (427,477.50)
FY 2003-04	$ 753,423.43	$ (560,639.21)
FY 2004-05	$ 701,433.47	$ (433,297.25)
FY 2005-06	$ 851,294.14	$ (643,294.14)
FY 2006-07	$ 982,438.69	$ (566,974.77)
FY 2007-08	$ 701,527.81	$ (243,993.06)
FY 2008-09	$ 727,889.97	$ (144,288.09)
FY 2009-10	$ 977,329.21	$ (661,446.32)
FY 2010-11	$ 1,210,354.62	$ (762,887.93)
FY 2011-12	$ 574,803.00	$ (161,273.91)
FY 2012-13	$ 427,886.50	$ (116,802.41)
FY 2013-14	$ 593,418.00	$ (185,851.20)
FY 2014-15	$ 719,749.29	$ (181,379.54)
FY 2015-16	$ 863,939.00	$ (430,818.00)
FY 2016-17*	$ 597,784.83	
Total:	**$ 11,115,448.49**	**$ (5,520,423.33)**

*Tulare received FY 2016-17 AB 915 reimbursement. However, audited cost reports are not yet available for FY 2016-17. Therefore, the AB 915 final reconciliation amount cannot be estimated at this time.